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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8093

08086

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coleman's Worton		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home RFD Worton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Demby Last		4. DATE OF DEATH Month July Day 18 Year 1961	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 1, 1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY various	
11c. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Demby		14. MOTHER'S MAIDEN NAME Katæe Garrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-30-2240	
17. INFORMANT Mary Demby RFD Worton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute right sided heart failure DUE TO old age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 16, 1961 to July 18, 1961 , that (I) (we) last saw the deceased alive on July 17, 1961 , and that death occurred at 5:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Florence D. Joyce		22b. DATE SIGNED 7/18/61	
22c. PHYSICIAN'S NAME (Type) Florence D. Joyce		22d. ADDRESS RFD Worton, Md.	
23a. BURIAL, CREMATION, (Specify) Burial		23b. DATE THEREOF July 23 1961	
23c. NAME OF CEMETERY OR CREMATORY Coleman's Cemetery		23d. LOCATION (City, town, or county) (State) RFD Worton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Wadley		25a. REC'D BY REGISTRAR DATE JUL 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

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CERTIFICATE OF DEATH

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(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08087											
1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Kent</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY in 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Worton</u>				d. STREET ADDRESS <u>1 RFD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kent & Queen Anne's Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Dorsey</u>						4. DATE OF DEATH Month Day Year <u>July August 8 1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/6/61 7pm</u>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months Days <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Donald Brooks</u>						14. MOTHER'S MAIDEN NAME <u>Agnes Dorsey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mother</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Fetal alcoholism -</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Chestertown, Md.</u>		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-6-61</u> to <u>7-8-61</u> , that (I) (we) last saw the deceased alive on <u>7-8-61</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert W. Farr</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-9-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>						22d. ADDRESS <u>Chestertown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Coleman Cemetery</u>		23d. LOCATION (City, town or county) <u>(near) Worton</u>		(State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walby</u>						ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

2072212XV1

1997



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8095

CERTIFICATE OF DEATH

08088

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) e. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY in 1b 5 days, 10 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital				d. STREET ADDRESS Rock Hall,			
3. NAME OF DECEASED (Type or print) James Dowling, Sr.				4. DATE OF DEATH Month 7 Day 2 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/86		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Dowling			
14. MOTHER'S MAIDEN NAME Annie Joiner				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 220 34 9395				17. INFORMANT Bertha Dowling, Rock Hall, Md. (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia with impending cardiac failure. 493X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphocytic leukemia, acute							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/27/61 , 19 61 , to 7/2/61 , 19 61 , that (I) (we) last saw the deceased alive on 7/2/61 , 19 61 , and that death occurred on 7/2/61 , 19 61 , from the causes and on the date stated above.							
22a. SIGNATURE William M. Latwood M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/5/61		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town or county) (State) Rock Hall Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill. Md.		25a. REC'D BY REGISTRAR JUL 12 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2203

2203

(M)

Kent

Maryland

Kent

Rock Hall,

9 days, 10 hrs.

Chesapeake

x

Kent & Queen Anne's Hospital

01

2

7

Bowling, Sr.

James

(Y)

75

3/12/66

x

White

Male

U.S.A.

Maryland

Genoa

Annie Johnson

John Bowling

220 34 2222 Bowling, Rock Hall, Md. (daughter)

No

Thrombosis with impending cardiac failure.

William M. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8096

08089

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home Piney Neck		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Lee Edwards		4. DATE OF DEATH Month Day Year July 25, 1961 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/1890
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Boats	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Clarence Edwards		14. MOTHER'S MAIDEN NAME Georganna Ashley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-16-6543	
17. INFORMANT Mrs. Nellie Edwards		Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular DUE TO (c) Hypertension			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 16, 1961 to July 23, 1961 , that (I) (we) last saw the deceased alive on July 23, 1961 , and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Norbert C. Nitsch		22b. DATE SIGNED 7/26/61	
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch		22d. ADDRESS Rock Hall, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/28/61	
23c. NAME OF CEMETERY OR CREMATORY St. John's Cem.		23d. LOCATION (City, town, or county) (State) Rock Hall, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DATE JUL 28 '61	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

0-072

CERTIFICATE OF DEATH

8002

(M)

Name of Deceased		Date of Birth	
John C. [illegible]		[illegible]	
Place of Birth		Date of Death	
[illegible]		[illegible]	
Cause of Death		Place of Death	
[illegible]		[illegible]	
Physician's Signature		Date of Certificate	
[illegible]		[illegible]	
Registrar's Signature		Date of Registration	
[illegible]		[illegible]	

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FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the full director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 16 Film G291 7/24/61 iwk 08090											
1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Betterton(rural)		c. LENGTH OF STAY IN b Lifetime		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Betterton(rural)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ---		d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) Paul First L Middle Ellis Last		4. DATE OF DEATH July Month 1 Day 61 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1937		9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 24 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service		10b. KIND OF BUSINESS OR INDUSTRY U. S. Coast Guard		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 24 HRS. Hours 0 Min. 0			
13. FATHER'S NAME Newton Ellis				14. MOTHER'S MAIDEN NAME Florence Willis							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 214-30-9111		17. INFORMANT Address Newton Ellis Betterton, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull, and other multiple injuries (short) 814X DUE TO Deceased was riding a motorcycle which Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) struck a deer crossing the road in front DUE TO of him, at about 12:30 AM today (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See above							
20c. TIME OF INJURY Hour 12:30 m. 7/1/61 Day 19 Year 61				20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway near Betterton		20f. (City or town) Kent		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Robert W. Farr				M.D. Robert W. Farr				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 1, 1961	
EXAMINER'S NAME (Type) Robert W. Farr				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/61		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery				22d. LOCATION (City, town, or country) (State) Chestertown, Maryland			
23. FUNERAL DIRECTOR Victor N. Kennedy				ADDRESS Still Pond, Md.				24a. REC'D BY REGISTRAR JUL 5 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8098

08091

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 6 hr 40 min		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pondtown - Chestertown Rural		d. STREET ADDRESS 17X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ella		First		Middle		Last		4. DATE OF DEATH July 5 19 61		Month		Day		Year			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-22-1933		9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY homes		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Hines		14. MOTHER'S MAIDEN NAME Susie Wicks Williams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records, Chestertown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic abortion and probable septicemia 651.0 Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		ACTUAL SIGNATURE Robert W. Farr		M.D. Robert W. Farr, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/6/61		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-8-1961		22c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT CEMETERY		22d. LOCATION (City, town, or country) (State) POND TOWN, RURAL CHESTERTOWN, Md.		23. FUNERAL DIRECTOR Edward Bellows, Millington, Md.		24a. REC'D BY REGISTRAR JUL 10 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Knease					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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08092

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golt d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle E. Last Hurd				4. DATE OF DEATH Month July Day 10 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1899	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Hurd				14. MOTHER'S MAIDEN NAME Katie Kemp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 220-26-2893		17. INFORMANT Mrs. Evelyn F. Hurd, Golt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO 2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO 2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 to July 12, 1961 , that (I) (we) last saw the deceased alive on July 10, 1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE GEZA KORALEWSKI				22b. DATE SIGNED July 12 61		22c. PHYSICIAN'S NAME (Type) GEZA KORALEWSKI	
22d. ADDRESS MILLINGTON MD				22e. REC'D BY REGISTRAR JUL 14 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Kline	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July, 13, 1961		23c. NAME OF CEMETERY OR CREMATORY Townsend Cemetery		23d. LOCATION (City, town or county) (State) Townsend, Del.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington Md.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part I may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Churchill, Winston
July 15, 1901
General Secretary
London, England
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above named subject.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
W. Churchill

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8100

08093

1. PLACE OF DEATH e. COUNTY Kent MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Watson Boarding Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY Queen Anne c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grasonville d. STREET ADDRESS 17 X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Herman Morris First Middle Last				4. DATE OF DEATH July 23, 1961 Month Day Year													
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH No Record 1895		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Fish Factory				11. BIRTHPLACE (County & State, or foreign country) Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME No Record						14. MOTHER'S MAIDEN NAME No Record											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 1				16. SOCIAL SECURITY NO. 219 07 5506				17. INFORMANT Sarah Watson, Address Millington, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart attack (Coronary occlusion) DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Tuberculosis of the lung (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2-3 years INTERVAL BETWEEN ONSET AND DEATH 4 years?																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Millington		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from March 15, 1961 to April 14, 1961 , that (I) (we) last saw the deceased alive on April 14, 1961 , and that death occurred at 1 P.M. , from the causes and on the date stated above.																	
22a. SIGNATURE GEZA KORALEWSKI						22b. DATE SIGNED July 24, 1961											
22c. PHYSICIAN'S NAME (Type) GEZA KORALEWSKI						22d. ADDRESS MILLINGTON, MD											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 25, 1961				23c. NAME OF CEMETERY OR CREMATORY Rileys Neck Cemetery				23d. LOCATION (City, town or county) Millington, Rural. Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows						25a. REC'D BY REGISTRAR JUL 27 61						25b. REGISTRAR'S SIGNATURE William S. Hume					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08094

1. PLACE OF DEATH e. COUNTY Kent f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Chestertown g. LENGTH OF STAY IN TB Life h. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home RFD # 2		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland f. COUNTY Kent g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown h. STREET ADDRESS RFD # 2 i. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) Joseph C. Quinn		4. DATE OF DEATH July 31, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1897
9. AGE (In years last birthday) 63		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Kent CO. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph C. Quinn		14. MOTHER'S MAIDEN NAME Abbie Estella Loller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-40-4525	
17. INFORMANT Francis A. Quinn		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rifle wound of head - the Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976X DUE TO Rifle was held in mouth - DUE TO shot.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depressed for two months			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self administered with 22 rifle	
20c. TIME OF INJURY 10:00 7/31 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) nr. Chestertown (County) Kent (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 8/1/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/61	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or country) Chestertown, Md.	
23. FUNERAL DIRECTOR J. Willis Wells		24a. REC'D BY REGISTRAR AUG 3 '61	
ADDRESS Chester Town, Md.		24b. REGISTRAR'S SIGNATURE Richard S. Kline	

MEDICAL CERTIFICATION



2073

MEDICAL EXAMINATION CERTIFICATE OF DEATH

NAME: JOSEPH C. GARRA
AGE: 45
SEX: M
DATE OF BIRTH: 10/10/1907
PLACE OF BIRTH: NEW YORK
OCCUPATION: LABORER
CAUSE OF DEATH: HEART DISEASE
MANNER OF DEATH: NATURAL
SIGNATURE: [illegible]
DATE: 10/10/1952

ALLIE WOODS OF DEATH

REPORTED FOR TWO MONTHS

ALL INFORMATION FURNISHED

10:00xx 7/31

AT A HOME

8/1/52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8102

08095

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 40 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 125 Plos. Terrace		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 125 Plos. Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) R. Lee Robinson		4. DATE OF DEATH July 29/61 Month July Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13 1893 yrs. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mail Clerk		10b. KIND OF BUSINESS OR INDUSTRY Postal	11. BIRTHPLACE (County & State, or foreign country) Chestertown Md.
13. FATHER'S NAME Edward Robinson		14. MOTHER'S MAIDEN NAME Sarah Ellen Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) no (If yes give war and date of service)		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Susie H. Robinson Address Chestertown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Coronary artery disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 1950 to July 29 1961 that (I) (we) last saw the deceased alive on July 25 1961 and that death occurred at 3:45 p.m. the causes and on the date stated above.			
22a. SIGNATURE A.C. Dick		22b. DATE SIGNED 7-30-61	
22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D.		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 1, 1961	23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	23d. LOCATION (City, town or county) (State) Chestertown, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR AUG 3 '61 DATE	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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8104

CERTIFICATE OF DEATH

Reg. Dist. No. 08097

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 2 MONTHS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Fairlee) Chestertown, Md.				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital			
d. STREET ADDRESS RFD Fairlee				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Urban Last Stein				4. DATE OF DEATH Month July Day 29 Year 1961			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1906	
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months 2 Days 12 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.	
10b. KIND OF BUSINESS OR INDUSTRY Bookkeeper (ret)		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Urban		14. MOTHER'S MAIDEN NAME Mary Urban	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 145-03-2798		INFORMANT Address Hospital Records - Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Cardiac, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vasc. Thrombosis & RT Hemiplegia DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE						INTERVAL BETWEEN ONSET AND DEATH 12 days 2 months YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-31- , 19 61 , to 7-29- , 19 61 , that I last saw the deceased alive on 7-29- , 19 61 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/29/61							
ACTUAL SIGNATURE Harry Paul Ross				M.D. Harry Paul Ross			
PHYSICIAN'S NAME (Type) Harry Paul Ross				Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/61		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				24a. REC'D BY REGISTRAR DATE AUG 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08098

1. PLACE OF DEATH a. COUNTY Kent MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent and Queen Anne Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Locust Grove d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George W. Webb		4. DATE OF DEATH July 13, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 18, 1889
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. BIRTHPLACE (County & State, or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Webb	
14. MOTHER'S MAIDEN NAME Katie Roeder		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Bessie O. Webb, Rural Kennedyville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Ventricular Fibrillation Coronary Thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3rd Coronary Arteriosclerosis - mild 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 7/13/61 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 7/8 19 61 , to 7/13 19 61 , that (I) (we) last saw the deceased alive on 7/13 19 61 , and that death occurred at 4:00 P. from the causes and on the date stated above. 22a. SIGNATURE Thomas J. Solon M.D. 22b. DATE SIGNED 7/14/61 22c. PHYSICIAN'S NAME (Type) Thomas J. Solon 22d. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY Church Hill Cemetery		23d. LOCATION (City, town or county) (State) Church Hill, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington Md.		25a. REC'D BY REGISTRAR July 18 '61 25b. REGISTRAR'S SIGNATURE Charles S. Hanna	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08093

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (Melitota)		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home (melitota)		e. STREET ADDRESS RFD	
3. NAME OF DECEASED (Type or print) First Romie Middle Williams Last Williams		4. DATE OF DEATH July 1, 1961 19	
5. SEX male	6. COLOR OR RACE colored	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Labor		12. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland	
13. FATHER'S NAME Washington Williams		14. MOTHER'S MAIDEN NAME Emma Houston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Verma Williams RFD Chestertown, Md. Wife		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephritis DUE TO 593X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 weeks DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10, 1961 to 7/1, 1961 , that (I) (we) last saw the deceased alive on 7/1/61 19 61 , and that death occurred at 5P.M. from the causes and on the date stated above.			
22a. SIGNATURE Eugene Kester M.D.		22b. DATE SIGNED July 1, 1961	
22c. PHYSICIAN'S NAME (Type) Eugene Kester		22d. ADDRESS Rock Hall, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 5, 1961	
23c. NAME OF CEMETERY OR CREMATORY Pomona Cemetery		23d. LOCATION (City, town, or county) (State) near - Chestertown, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Benneth Walby ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR Jul 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8107
CERTIFICATE OF DEATH

08100

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Annes		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS (Gratitude) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last VINCENT JOSEPH WILLIAMS		4. DATE OF DEATH Month Day Year July 28 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1896
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Roofing Supplies Pennsylvania	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Joseph Williams		14. MOTHER'S MAIDEN NAME Margaret O'Erian	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 198-09-4997	
17. INFORMANT Hospital Records		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary fibrosis due to old Pulmonary Tbc. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 years 30-40 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Polycythemia due to 18, part 1; and right sided pneumothorax			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/6 to 7/28 , 19 61 , that (I) (we) last saw the deceased alive on 7/28/61 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Farr		22b. DATE SIGNED July 28, 1961	
22c. PHYSICIAN'S NAME (Type) Robert W. Farr		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 7/29/61	23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory	23d. LOCATION (City, town or county) (State) Wilmington, Delaware
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DATE JUL 31 '61	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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Major O'Brien

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